

SCHEDULE 2 – THE SERVICES

A. Service Specifications

This is a non-mandatory model template for local population. Commissioners may retain the structure below, or may determine their own in accordance with the Contract Technical Guidance.

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|----------------------------------|--|
| Service Specification No. | |
| Service | Improving Access to Psychological Therapies (IAPT) – Core and Integrated |
| Commissioner Lead(s) | Nicola Bromage, Strategic Senior Lead, Staffordshire CCGs Matthew Beardmore, Strategic Senior Manager, Staffordshire CCGs |
| Provider Lead | Dr Mark Kenwright, Clinical Lead, MPFT |
| Period | 1 st April 2020 to 31 st March 2023 (with option of a two further year (1+1)) |
| Date of Review | |

1. Population Needs

1.1 National Context

Emerging mental health policy is driving significant change with an emphasis on wellbeing and building care around individual needs through choice and flexibility, with Improving Access to Psychological Therapies (IAPT) being a core aspect of this Department of Health (DH) priority.

The national priorities for service development are¹:

- Expanding services so that at least 1.5m adults access care each year by 2020/21. This means that IAPT services nationally will move from seeing around 15% of all people with anxiety and depression each year to 25%, and all areas will have more IAPT services;
- Focusing on people with long term conditions. Two thirds of people with a common mental health problem also have a long term physical health problem, greatly increasing the cost of their care by an average of 45% more than those without a mental health problem. By integrating IAPT services with physical health services the NHS can provide better support to this group of people and achieve better outcomes;
- Supporting people to find or stay in work. Good work contributes to good mental health, and IAPT services can better contribute to improved employment outcomes;
- Improving quality and people's experience of services. Improving the numbers of people who recover, reducing geographic variation between services, and reducing inequalities in access and outcomes for particular population groups are all important aspects of the development of IAPT services.

¹ <https://www.england.nhs.uk/mental-health/adults/iapt/>

The following are key documents/resources which have informed this service specification:

- **Talking Therapies: A four-year plan of action (November 2011):** This supports **No health without mental health (February 2011)**. As well as ensuring that there is a complete roll-out of IAPT services and equitable access for all adults (including older people) and a stand-alone programme for children and young people, 'Talking Therapies; A four year action plan' focused on developing models of care for people with long term physical health conditions, medically unexplained symptoms and severe and enduring mental illness.
- **The five year forward view for mental health (February 2016):** This report from the independent mental health taskforce for NHS England sets out a strategy for delivering mental health care with specific recommendations to be met by 2021. These include improving access to psychological therapies for: children and young people; perinatal mental health; people with long term physical conditions; those with severe and prolonged mental illness, and a renewed focus on enabling those who are unemployed due to mental health problems to return to work through employment support. This report recommends an expansion of the improving access to psychological therapies programme to meet some of these recommendations.
- **Better Births (February 2016):** Better Births sets out a vision for safe and efficient models of maternity care: safer care, joined up across disciplines, reflecting women's choices and offering continuity of care along the pathway. The review outlined 7 key recommendations one of which is better postnatal care and perinatal mental healthcare, to address under provision in these two vital areas which can have a significant impact on the life chances and wellbeing of the woman, baby and family.
- **Improving Access to Psychological Therapies Manual (June 2018):** A manual for IAPT services, describing the IAPT model in detail and how to deliver it, with a focus on the importance of providing National Institute for Health and Care Excellence (NICE)-recommended care
- **The NHS Long Term Plan (January 2019):** The NHS Long Term Plan sets out a series of objectives on mental health care over the next ten years. These include:
 - Expanding support for perinatal mental health conditions;
 - Increasing funding for children and young people's mental health;
 - Bringing down waiting times for autism assessments;
 - Providing the right care for children with a learning disability;
 - Spending at least £2.3bn more a year on mental health care;
 - Helping 380,000 more people get therapy for depression and anxiety by 2023/24;
 - Delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.

Reducing the prevalence of common mental health disorders is a major public health concern. In 2007, the annual cost to treat depression and anxiety disorders in England was nearly £3 billion, with an additional economic impact of around £13 billion in lost earnings among people of working age.

There is strong evidence that appropriate and inclusive services and pathways for people with common mental health problems – specifically depression and anxiety – reduce an individual's usage of NHS services whilst contributing to overall mental wellbeing and economic productivity.

The NHS Long Term Plan sets out a target that by 2023/24 an additional 380,000 people per year will be able to access NICE-approved IAPT services².

² NHS Long Term Plan p. 73 (Milestones for mental health services for adults)

Review of current IAPT services have shown, through routine collection of outcome measures, the following benefits for people receiving services³:

- Better health and wellbeing;
- High levels of satisfaction with the service received;
- More choice and better accessibility to clinically effective evidence-based services;
- Helping people stay employed and able to participate in the activities of daily living.

The Commissioning Guide for Common Mental Health Disorders⁴ suggests that 17.7% of the adult population (18+) will have a mental or emotional condition, which would benefit from an intervention at primary care level.

Talking Therapies; A four year action plan⁵ set a target of 15% (of the 17.7% adults 18+) to access interventions locally, however **The five year forward view for mental health**⁶ recommends that this is expanded from 15% to 25% by 2021.

Around one-third of people with long term conditions (LTCs), such as diabetes, cardiovascular disease and respiratory disease, will also experience a common mental health problem, with an even higher proportion experiencing poor mental health. Coexisting mental and physical health problems are associated with a poorer prognosis and considerably higher healthcare costs.

Despite the distress to the individual and costs to health and social care services and the wider society associated with mental health problems; they are often under-recognised and under-treated in people with LTCs and medically unexplained symptoms (MUS).

LTCs are common and currently affect 16.5 million people in England. Of these, over 30% of people will also experience a common mental health problem. This is two to three times higher than the prevalence in the general population.

Rates of depression and anxiety disorders in people with MUSs are also higher than in the general population. One study found that 52% of people attending specialist pain clinics met the diagnostic criteria for depression.

Integrated care, as well as being reported consistently as preferable to non-integrated care by people who receive it, has also been shown to improve outcomes and be cost effective.

1.2 Local Context

Further local context can be found within the pan Staffordshire mental health and mental wellbeing strategy **Mental Health is Everybody's Business (2015)** which was agreed across the health and social care economy in Staffordshire for 2015-2020.

The English Indices of Deprivation 2015 showed that Stoke-on-Trent was ranked 17th and Staffordshire ranked 116th out of 152 (lower ranking evidencing an area that is more deprived) based on the average rank on the Indices of Multiple Deprivation (IMD) 5⁷.

Within Staffordshire, this can be further broken down into borough council areas as shown below:

Fig. 1: Indices of Deprivation: Staffordshire rankings

| Area | Ranking (out of 326) |
|------|----------------------|
|------|----------------------|

³ <http://www.nmhd.org.uk/news/improving-access-to-psychological-therapies/>. Accessed 13th June 2012 at 4pm

⁴ NICE commissioning guide 41. Commissioning stepped care for people with common mental health disorders. November 2011

⁵ The Department of Health: Talking Therapies; A four-year action plan. February 2011.

⁶ <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

⁷ Indices of Multiple Deprivation analysis: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

| | |
|--------------------------------|-----|
| Cannock Chase | 128 |
| Tamworth | 144 |
| Newcastle-under-Lyme | 161 |
| East Staffordshire | 163 |
| Staffordshire Moorlands | 203 |
| Stafford | 243 |
| Lichfield | 252 |
| South Staffordshire | 253 |

The table below details prevalence of LTC conditions across all six CCGs:

Fig. 2: Local prevalence of LTC conditions across Stoke-on-Trent and Staffordshire CCGs⁸

| CCG | COPD | Asthma | Diabetes | Heart Failure |
|--|-------------|---------------|-----------------|----------------------|
| NHS Cannock Chase CCG | 2.49% | 5.90% | 7.83% | 0.98% |
| NHS East Staffordshire CCG | 1.85% | 6.14% | 7.20% | 1.05% |
| NHS North Staffordshire CCG | 2.40% | 6.39% | 7.57% | 0.88% |
| NHS South East Staffordshire and Seisdon Peninsular CCG | 1.84% | 6.23% | 7.10% | 0.88% |
| NHS Stafford and Surrounds CCG | 1.71% | 6.08% | 6.67% | 0.84% |
| NHS Stoke-on-Trent CCG | 2.60% | 6.28% | 8.12% | 0.86% |

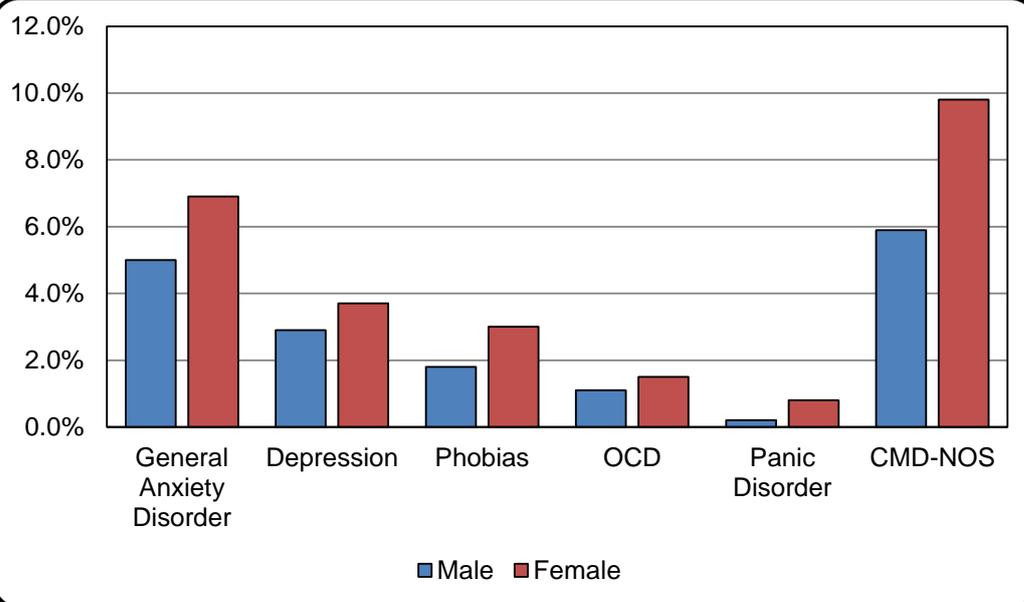
1.3 Evidence Base

In 2014, 19.7% of people in the UK aged 16 and older showed symptoms of anxiety or depression – a 1.5% increase from 2013. This percentage was higher among females (22.5%) than males (16.8%).

The APMS (2014) reports that, in England, the rates of common mental health problems are highest in the South West (20.9%), North West (19%), **West Midlands (18.4%)** and London (18%). They are lowest in the South East (13.6%) and the East (14.4%).

Figure 3: APMS prevalence of common mental health problems by gender

⁸ Quality and Outcomes Framework (QOF) – 2017/18



2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

| | | |
|----------|--|---|
| Domain 1 | Preventing people from dying prematurely | |
| Domain 2 | Enhancing quality of life for people with long-term conditions | ✓ |
| Domain 3 | Helping people to recover from episodes of ill-health or following injury | ✓ |
| Domain 4 | Ensuring people have a positive experience of care | ✓ |
| Domain 5 | Treating and caring for people in safe environment and protecting them from avoidable harm | ✓ |

2.2 Local Defined Outcomes

The Key Outcomes for the service shall be:

- Service Users shall receive timely (see waiting times) access to assessment and relevant treatment;
- Service Users shall be able to choose from a range of relevant evidence based treatments;
- Service Users shall be able to attend appointments at a time suitable to them taking into consideration their working hours;
- Services Users shall have a choice of access to the service in a GP practice or other suitable premises;

- Service Users shall show clinically significant improvement in their mental health and wellbeing after treatment;
- Improved inclusion and employment status, including:
 - Maintaining people in work and involvement in activities of daily living;
 - Supporting people in returning to work and participating in activities of daily living.
- On discharge service users shall be facilitated, if they wish, to become involved in peer support groups, community groups and volunteering;
- The service shall be available equitably across Stoke-on-Trent and Staffordshire in terms of geographical spread and Service User Group(s);
- Service Users shall indicate satisfaction with their experience of this service;
- GPs shall indicate satisfaction with their experience of this service.

3. Scope

3.1 Aims and objectives of service

The overall aim of the Service is to provide timely and responsive psychological service to the people of Stoke-on-Trent and Staffordshire who are experiencing any mental health problem that can be treated effectively in primary care – a single point of access for all mental health problems in primary care. This will include both:

- The treatment of common mental health problems (depression and anxiety disorders) where those conditions can be managed in primary care, as part of the Improving access to psychological therapies programme, delivered by IAPT workers;
- The treatment of other “Non-IAPT” mental health problems that can benefit from an evidence-based psychological therapy, delivered by “Non-IAPT” workers (e.g. Community Mental Health Nurses, counsellors, therapists, recovery/support workers, peer support workers and other mental health professionals).

Common mental health problems to be treated by IAPT services are defined as⁹:

- Depression;
- Generalised anxiety disorder;
- Social anxiety disorder;
- Panic disorder;
- Agoraphobia;
- Obsessive compulsive disorder (OCD);
- Specific phobias (such as height or small animals);
- Post-traumatic stress disorder (PTSD);
- Health anxiety (hypochondriasis);
- Body dysmorphic disorder mixed depression and anxiety (the term for sub-syndromal depression and anxiety, rather than both depression and anxiety).

The Provider shall deliver a high quality, patient-centred service that enables people with mental health problems to improve their well-being and functionality, thereby reducing the need for more specialist services (either for their mental or physical health). Therefore, the Service shall also provide the connectivity for Service Users in terms of their wider care, ensuring that it is inclusive of both mental health and physical health problems.

The Provider shall be expected to work with the community and voluntary sector to deliver the Service, particularly in relation to the non-IAPT element.

Delivery will be an integral aspect of primary care services therefore flexibility will be key in order to ensure individual GP practice needs can be met. The vision for the service is the provision of

⁹ IAPT Manual Section 1.3.1 Who IAPT is for

an integrated primary care mental health service which is accessible, flexible and innovative in addressing the needs of the individuals accessing the service. In order to achieve this, therapists should work as part of GP practice teams, working flexibly to meet the individual needs of each practice.

The Service shall be culturally sensitive and available for every member of the community and shall ensure that there is wider network and partnership working so that Service Users are not left without adequate support.

The Services main objectives are to:

- Increase the proportion of people who are identified, assessed and receive treatment in accordance with NICE guidance/evidence based psychological care by appropriately qualified clinicians;
- Provide easy, timely access to services to suit patients (i.e. hours of service, weekends, local location and facilities);
- Provide tailored individual care plans describing anticipated treatment and discharge planning;
- Improve the proportion of people who make clinically significant improvements or recover;
- Improve emotional wellbeing, quality of life and functional ability in people with common mental health disorders;
- Improve individual's wellbeing and functionality; this shall include people with physical health problems;
- Improved choice and access to evidence based psychological treatments;
- Provide signposting, information and support to facilitate access to a range of community based support services;
- Improve the experience of Service Users and their carers;
- Improve identification and awareness of common mental health disorders (e.g. through awareness training for a range of health, social care and education and welfare professionals) and promote onward referral for assessment and intervention;
- Improve the interface between services for people with common mental health disorders with an emphasis on those pathways between primary care based services and secondary care;
- Reduce the number of patients referred between primary and secondary care mental health services by treating more people effectively in primary care, so patients only have to "tell their story once", and reduce the stigma of treatment by providing quick and easy access in a "Non-mental Health", primary care location;
- Improve access and support to maintain people in work, help them to return to work, help them into education or training and where appropriate help people find meaningful activity;
- Reduce inappropriate usage of emergency care services for people with co-existing physical health and common mental health disorders;
- Effective joint working across physical health and mental health teams.

The underlying principles are to:

- Promote positive mental health within the community;
- Promote and support self-care with all patients;
- Patients should have information provided in a variety of formats so they can decide what is most useful to them e.g. written, oral, electronic in line with the NHS England Accessible Information Standard¹⁰;
- Patients with long term conditions have a high level of depression and anxiety and should be seen within the service to support their self-management;
- Group work, psycho-educational groups should be considered where appropriate;
- Outcomes measures should be used to support patients through their treatment and to provide evidence of effectiveness;
- Where possible patients will be seen in their own practice unless they request otherwise;

¹⁰ <https://www.england.nhs.uk/ourwork/accessibleinfo/>

- Support to families and carers in terms of assessment of their own caring, physical, social, occupational and/or mental health needs and information on how they can support the person or access relevant support groups and networks.

3.2 Service Description/Care Pathway

The Service shall be integrated with Long Term Condition teams, and primary care teams, providing psychological therapies within a Stepped Care Model, to people who are experiencing common mental health problems (the IAPT section of the service), and other mental health problems (the Non-IAPT section of the service).

These are identified (in relevant NICE guidance) as being appropriate to be managed in primary care (please see fig. 4 below for details):

Fig. 4: NICE indicated treatments for depression and anxiety disorders

| | Condition | Psychological Therapies | Source |
|---|--|---|--|
| Step 2: Low-intensity interventions (delivered by PWP) | Depression | Individual guided self-help based on CBT, computerised CBT, behavioural activation, structured group physical activity programme | NICE guidelines: CG90, CG91, CG123 |
| | Generalised anxiety disorder | Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT | NICE guidelines: CG113, CG123 |
| | Panic disorder | Self-help, or guided self-help, based on CBT | NICE guidelines: CG113, CG123 |
| Step 3: High-intensity interventions | Depression For individuals with mild to moderate severity who have not responded to initial low-intensity interventions | CBT (individual or group) or IPT Behavioural activation Couple therapy ^a Counselling for depression Brief psychodynamic therapy Note: psychological interventions can be provided in combination with antidepressant medication. | NICE guidelines: CG90, CG91, CG123 |
| | Depression Moderate to severe | CBT (individual) or IPT, each with medication | |
| | Depression Prevention of relapse | CBT or mindfulness-based cognitive therapy ^b | |
| | Generalised anxiety disorder | CBT, applied relaxation | NICE guidelines: CG113, CG123 |
| | Panic disorder | CBT | NICE guidelines: CG113, CG123 |
| | Post Traumatic Stress Disorder | Trauma-focused CBT, eye movement desensitisation and reprocessing ^c | NICE guidelines: CG26, CG123 |
| | Social anxiety disorder | CBT specific for social anxiety disorder ^d | NICE guideline: CG159 |
| | Obsessive-compulsive disorder | CBT (including exposure and response prevention) | NICE guidelines: CG31, CG123 |
| | Chronic fatigue syndrome | Graded exercise therapy, CBT* | NICE guideline: CG53 |
| | Chronic pain | Combined physical and psychological interventions including CBT* and exercise | NICE guideline: NG59 Informal consensus of the ETG ^e |
| | Irritable bowel syndrome | CBT* | NICE guideline: NG61 Informal consensus of the ETG |
| | MUS not otherwise specified | CBT* | Informal consensus of the ETG |

Notes:

NICE depression guidance currently being updated.

*Specialised forms of CBT.

^a If the relationship is considered to be contributing to the maintenance of the depression, and both parties wish to work together in therapy. IAPT recognises two forms of couple therapy and supports training courses in each. One closely follows the behavioural couple therapy model. The other is a broader approach with a systemic focus.

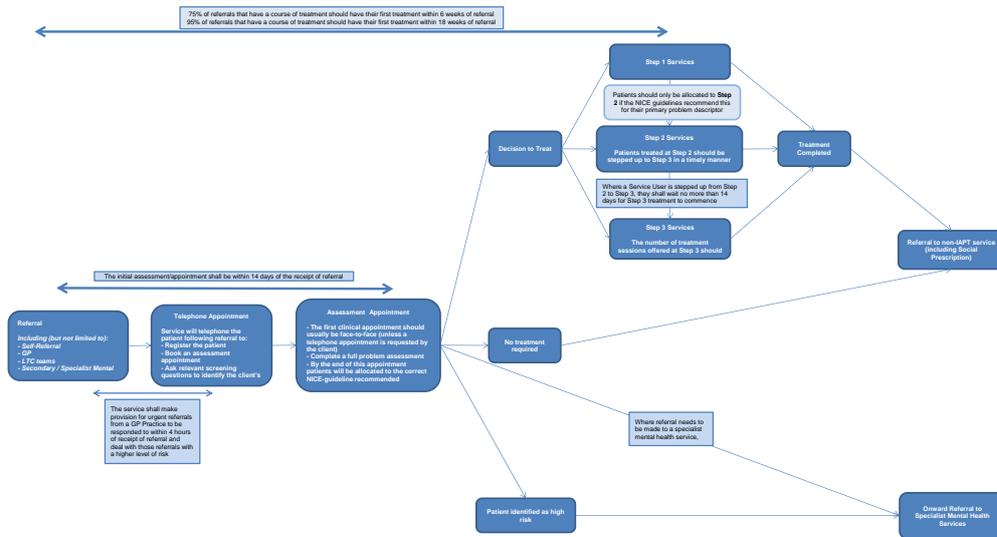
^b CBT during treatment in the acute episode and/or the addition of mindfulness-based cognitive therapy when the episode is largely resolved. Mindfulness is not recommended as a primary treatment for an acute depressive episode.

c If no improvement, an alternative form of trauma-focused psychological treatment or augmentation of trauma-focused psychological treatment with a course of pharmacological treatment.
 d Based on the Clark and Wells model or the Heimberg model.
 e The NHS England IAPT Education and Training Group (ETG) was convened to undertake a review of problem-specific systematic reviews and extrapolation from NICE guidance for the treatment of depression and anxiety disorders in the context of LTCs and for the treatment of MUS.

If - upon assessment - it is apparent that a patient requires secondary care treatment, the service shall ensure that the patient is directly referred to the appropriate secondary care service, rather than passed back to the GP to refer. This will ensure no unnecessary delays in the patient's treatment.

A copy of the proposed pathway(s) is shown below:

Fig. 5: IAPT Service Pathway



3.2.1 IAPT Service

The IAPT section of the Service shall provide the following:

- Evidence-based Psychological Therapies in line with NICE recommendations, including but not limited to –
- Cognitive Behavioural Therapy (CBT) – Anxiety Disorders & Depression;
- Interpersonal Therapy (IPT) – Depression;
- Behavioural Couples Therapy – Depression;
- Counselling & Brief Psychodynamic Therapy – Depression;
- Brief CBT-based interventions delivered in Guided Self-Help Packages by Psychological Wellbeing Practitioners at Step 2, including:
 - Behavioural Activation;
 - Psycho-education;
 - Problem Solving;
 - Sleep hygiene;
 - Sign posting to range of local support agencies/organisations.

3.2.2 Non IAPT Service

The Non-IAPT section of the service shall provide the following:

- Solution focused therapy;
- CBT-based treatment programmes for Non-IAPT problems (e.g. low self-esteem, eating disorders);
- Counselling for Non-IAPT problems;
- Case management including co-ordinating care with other services such as physical care services and drug and alcohol where service users have multiple care and support needs;

- Appropriate referral and signposting support to access community based and voluntary sector mental health services;
- All sections of the service shall provide -
 - Social prescribing, such as exercise on prescription and signposting and support to use self-help materials (e.g. books on prescription/ bibliotherapy), signposting and support to access mainstream community services, e.g. housing, employment, financial advice, parenting advice;
 - Advice on healthy living and support to access services that promote good health and physical wellbeing;
 - Advice and education for primary care staff and others on mental health promotion and the availability of community and voluntary sector services;
 - Services and support to GP practices in Stoke-on-Trent and Staffordshire to meet the needs of adults with common mental health disorders/other problems;
 - Liaison with GPs and others to assess appropriateness of the services provided to meet the needs of the population of Stoke-on-Trent and Staffordshire;
 - Specific support to people whose first language is not English.

Services shall be provided where the least intensive intervention appropriate to personal needs is provided first and people can step up or down the care pathway in accordance with their changing needs and response to treatment. Service Users should expect to receive appropriate NICE-compliant IAPT interventions from a skilled and qualified workforce.

The Service shall also work in accordance with agreed relevant care pathways in the wider health economy.

The Service shall be accessible, flexible and innovative in addressing the needs of the individuals accessing the Service and shall therefore offer a range of resources and interventions (i.e. a treatment system), again in line with relevant Mental Health Legislation, NICE guidance and current evidence practice.

The Service shall work in a collaborative manner and liaise closely with secondary care clinicians/mental health practitioners, primary care clinicians, integrated locality care teams, peer led user groups and voluntary sector organisations to ensure that Service Users' needs are met holistically balancing physical, social and psychological needs of the individual and their carer/s.

The Service shall establish clinically integrated pathways for Service Users with a range of co morbidities such as, long-term conditions and severe and enduring mental illness as well as those Service Users with medically unexplained symptoms or have other lifestyle issues.

3.3 Population Covered

The Service is for people who are registered with a General Practice within the Stoke-on-Trent and Staffordshire boundaries.

For people who are not registered with a General Practice, the Service shall be open to people for whom one of the following six CCGs of Stoke-on-Trent and Staffordshire are recognised as being responsible commissioners:

- Cannock Chase CCG;
- East Staffordshire CCG;
- North Staffordshire CCG;
- South East Staffordshire and Seisdon Peninsular CCG;
- Stafford and Surrounds CCG;
- Stoke-on-Trent CCG

If a person is residing temporarily within the area, but is registered with a GP elsewhere (e.g. a student) they shall be entitled to access the Service if it is clinically appropriate.

The IAPT Service shall provide interventions for people aged 16 years or older with the appropriate level of need who are experiencing common mental health problems. This shall include:

- Depression;
- Generalised anxiety disorder;
- Mixed depression and anxiety;
- Panic disorder, with or without Agoraphobia;
- Obsessive-compulsive disorder and Body Dysmorphic Disorder;
- Phobias (including social anxiety disorders (social phobia));
- Post-traumatic stress disorder;
- Health anxiety (hypochondriasis);
- Anxiety and/or depression associated with Long Term Physical Conditions;
- Medically Unexplained Symptoms.

The Non-IAPT section of the service shall provide treatment for people aged 16 years or over who are experiencing any mental health problem with a level of need that can be met by one therapist providing a talking therapy in primary care. Problems not traditionally suitable for primary care services should not form exclusion criteria, as the service should be tailored to meet individual need. Suitability should be based more on whether the person can engage effectively with treatment in primary care.

Non-IAPT problems treated shall include:

- Eating disorders;
- Personality disorders;
- Psycho-sexual problems;
- Bipolar depression;
- Drug/alcohol problems;
- Other (where deemed clinically appropriate).

It is also expected that Service Users with more complex needs, and those in hard to reach groups, such as carers, older people, veterans, asylum seekers, refugees and people whose first language is not English shall also be considered for the Service.

The provider will ensure that appropriate facilities and support are in place for those patients requiring interpretation, translation and British Sign Language services as per NHS England Guidance.¹¹

3.3.1 Service Users with further health problems

The Service shall be expected to work with all Service Users who are experiencing common mental health problems regardless of any other health problems they are experiencing, providing that they are likely to benefit from the Service, that their needs are capable of being managed within the Service, and that the level of risk is acceptable for a primary care-based service.

This would include, for example, people with long-term conditions of all types, including (for example) diabetes, vascular problems and stroke, people with physical disabilities. The Service shall agree pathways and protocols with physical health providers for people who have a LTC.

Co-morbid mental health conditions

Where a Service User has non-acute or stable psychosis and anxiety or depression-related symptomatology is present, it is expected that the Service shall consider the Service User for therapy.

Substance misuse

¹¹ Guidance for commissioners: Interpreting and Translation Services in Primary Care standards

It is likely that a number of Service Users with common mental health problems shall also be involved in some level of substance use, misuse or abuse, for example, excessive consumption of alcohol as self-medication, or the use of illegal substances.

The Service shall be expected to provide mental health services to Service Users who use substances, and work closely with drug and alcohol services to co-ordinate the care so that Service Users are able to participate effectively in their therapy and benefit from the care and support offered. The Service shall agree pathways and protocols with substance misuse providers as to which service will be the lead agency in dealing with Service Users who have mental health and substance misuse issues.

Autism, Mild learning disability or cognitive impairment

The Service shall be expected to work with Service Users with learning disabilities, mild cognitive difficulties, Autistic Spectrum Conditions or Dementia. The Service shall agree pathways and protocols with other providers involved with the Service User as to which service will be the lead agency in enabling these Service Users to access psychological support. However if Service Users have significant impairment due to their condition which would prevent them from gaining benefit from the therapy and support available then it is not expected that they would be treated by the Service.

Homeless

The Service shall be expected to work the homeless and develop pathways and protocols for this group of Service Users.

The Service shall develop shared care arrangements with other relevant services to ensure Service Users' needs are fully met, and all aspects of their care and treatment coordinated. If the Service is not able to work with the person for any reason they should ensure that, they are referred by their GP to suitable alternative provision to manage their mental health needs.

Perinatal mental health

Around one in four women experience mental health problems in pregnancy and during the 24 months after giving birth¹². The consequences of not accessing high-quality perinatal mental health care are estimated to cost the NHS and social care £1.2 billion per year.

As set out in The Long Term Plan, IAPT services will improve access to and the quality of perinatal mental health care for mothers, their partners and children by:

- Increasing access to evidence-based care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis;
- Care provided by specialist perinatal mental health services will be available from preconception to 24 months after birth (care is currently provided from preconception to 12 months after birth), in line with the cross-government ambition for women and children focusing on the first 1,001 critical days of a child's life;
- Expanding access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions;

¹² Howard, L., Ryan, E., Trevillion, K., Anderson, F., Bick, D., Bye, A., Byford, S., O'Connor, S., Sands, P., Demilew, J., Milgrom, J. & Pickles, A. (2018) Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy. *The British Journal of Psychiatry*, 212 (1), 50-56. Available from: <https://doi.org/10.1192/bjp.2017.9>

- Offering fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support as required. This will contribute to helping to care for the 5-10% of fathers who experience mental health difficulties during the perinatal period¹³;
- Increasing access to evidence-based psychological support and therapy, including digital options, in a maternity setting. Maternity outreach clinics will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience.

3.4 Any acceptance and exclusion criteria and thresholds

This service would provide interventions for people aged 16 + (*please note GPs should assess maturity level for those patients 16-18 and should consider CAMHS referral if more appropriate*) with the appropriate level of need specifically:

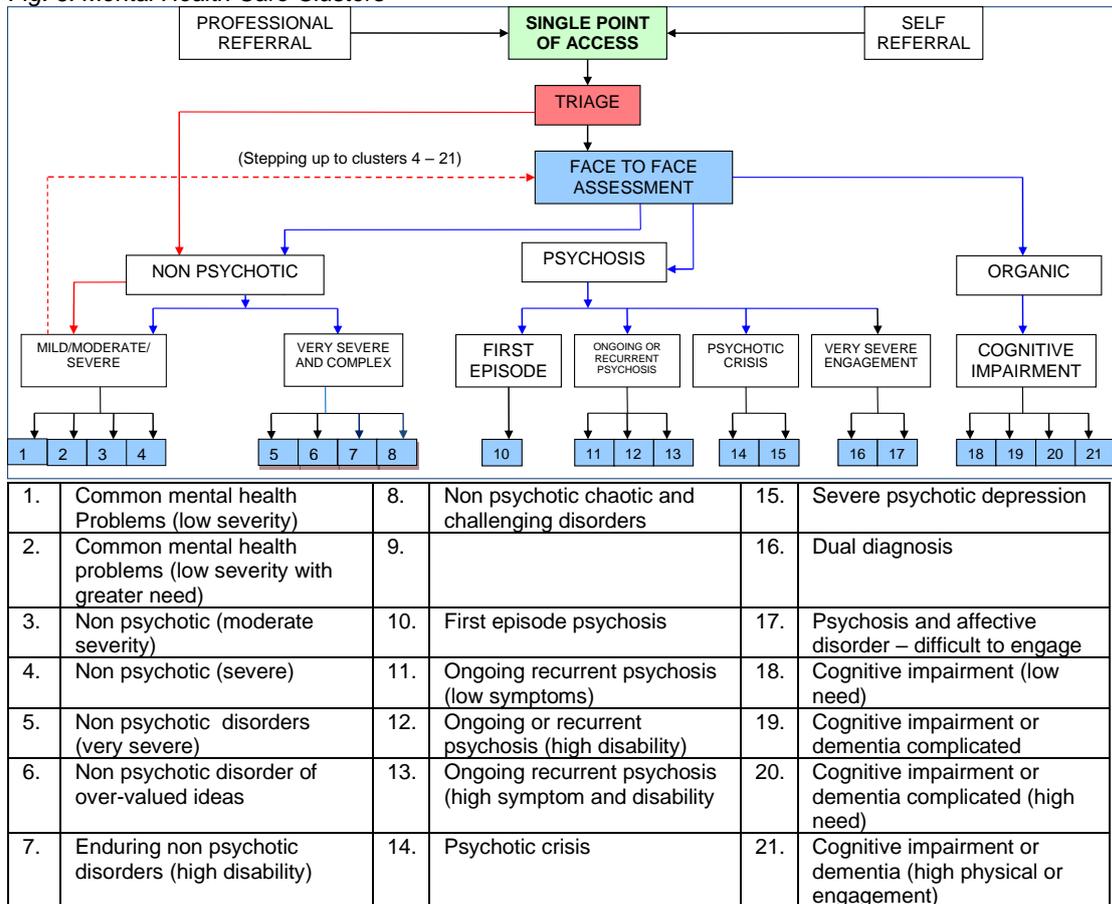
The services will address Mental Health Care Clusters 1-8 as follows:

- Care Cluster 1: Common Mental Health Problems (Low Severity) - This group of service users has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms;
- Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need) - This group of service users has definite but minor problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with Care Cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms;
- Care Cluster 3: Non-Psychotic (Moderate Severity) - This group of service users have moderate problems involving depressed mood;
- Care Cluster 4 to 7 : Non-Psychotic (Severe, Very Severe and Complex) - This group of service users is characterised by severe depression and/or anxiety and/or other disorders, and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.
- Care Cluster 8 Non-Psychotic Chaotic and Challenging Disorders - If the psychological therapist is an experienced clinician and the service user does not require multi-disciplinary case/care management and/or other co-morbidities (e.g. borderline

¹³ Paulson, J. & Bazemore, S. (2010) Prenatal and Postpartum Depression in Fathers and Its Association With Maternal Depression: A Meta-analysis. JAMA. 303 (19), 1961–1969. Available from: <https://doi.org/10.1001/jama.2010.605>

personality disorder) are not the primary focus of treatment, and is not under mental health secondary care, then these more complex and severe cases could also be treated within the Psychological Therapies Services (Adults).

Fig. 6: Mental Health Care Clusters



This will include service users with these levels of need who use alcohol and/or drugs as a coping mechanism. In addition the service will accept patients with personality disorders where the main presenting condition is anxiety or depression.

The following are excluded from this psychological therapy services:

- Acute psychosis;
- Actively suicidal, risk to themselves or significant self-neglect;
- Patients who pose a high risk to staff or others;
- Patients who need to be primarily referred for forensic or neuropsychological assessment;
- Significant impairment of cognitive function (e.g. dementia); significant impairment due to autistic spectrum problems or learning difficulties;
- People with a diagnosis of a severe and enduring mental illness who are currently active to secondary mental health services;
- People who have consistently not engaged with previous therapy treatment options offered (to be agreed on an individual need);
- Patients with significant eating disorders.(separate service for these patients);

3.5 Interdependence with other services/providers

The key relationship for the Service is with General Practitioners, and each general practice shall have a Practice Therapist located in the surgery, working flexibly as part of the practice team, so that a strong relationship can be developed between the Service and general practice staff.

The Service shall establish a key relationship with both Midlands Partnership Foundation Trust and North Staffordshire Combined Healthcare NHS Trust (this shall typically be via the Access Team) to facilitate access to secondary mental health services and to ensure that Service Users can be seamlessly stepped up or down between services which are clinically appropriate in a timely and easy manner.

The Practice therapists from the service shall also work as part of Integrated Locality Care Teams and Multi-speciality Community Providers (MCPs) in Stoke-on-Trent and Staffordshire, and shall ensure that the General Practice Therapists work seamlessly between the two services.

To ensure that Service Users, who have a chronic health problem, medically unexplained symptoms, substance misuse issues etc, receive appropriate and timely treatment from the Service, the Provider shall ensure that they work closely and co-operatively with key health services and agencies across Stoke-on-Trent and Staffordshire. Where possible the integrated IAPT therapists will co-locate with existing LTC teams and deliver joint clinics.

The Service shall also ensure it has “signposting” relationships with a range of other services that address factors linked to mental health and wellbeing, to services that address physical health needs and services available to the population in general (including the voluntary sector).

Where necessary the Service shall develop shared care arrangements with other relevant services to ensure Service User's needs are fully met and all aspects of their care and treatment coordinated.

To ensure that the Service is safe, integrated and effective, clear pathways for people to move into, through and out of the Service are required. Mechanisms for resolution or disputes at various stages of the care pathway are essential.

3.6 Whole system relationships

The Service shall ensure that it has an integrated holistic approach that considers a person's wider quality of life needs. This whole life approach shall require the Service to work closely with a range of other organisations to demonstrate improvements.

The Service forms part of a spectrum of services commissioned by all six Staffordshire CCGs to address the Mental Health Needs of its population.

It is specifically responsible for responding to people with common mental health problems, and in doing so, to work in partnership with other services responding to the needs of this group of people. This includes employment support services, general practice and community health services, social care services, housing services, services working with substance use, services working with people with physical and/or sensory disabilities, services working with minority ethnic communities and services and support provided to promote mental wellbeing.

It also needs to work with services that provide support to the population as a whole, including services provided in the voluntary and community sectors as well as statutory agencies.

3.7 Training, education and research activities

The Service shall carry out training with partner agencies, in the identification of common mental health problems, shall work (in conjunction with others) to educate universal and other services to the general public on mental health and wellbeing issues relevant to the Service User group.

The Service shall conduct research where appropriate on issues relevant to the service area and Service User group and shall contribute to Local, Regional and National networks linked to the IAPT programme.

The Service is responsible for training and supporting relevant partner agencies in the use of their recording system and in their use of the tools and scales associated with the IAPT programme.

3.8 Workforce

The Service Provider shall appoint a clear and identifiable Clinical Lead who shall have doctoral level training/qualifications and experience in psychological therapies service delivery to ensure the success of the Service, and who shall be accountable for the quality, governance, and delivery of the identified service outcomes and overall performance.

3.8.1 Staffing levels

The Service's workforce must have, at all times, the skills and experience to deliver the required levels of therapeutic intensity specified in relevant stepped care guidance and workforce numbers must be sufficient to deliver this.

The impact assessment for '**Talking therapies: a four year plan of action**' estimates that of those adults identified as having a common mental health disorder and entering treatment:

- Approximately 2/3 will have a mild disorder requiring low-intensity psychological therapy treatment at Step 2;
- Approximately 1/3 will have a moderate or severe disorder requiring high-intensity psychological therapy treatment at Step 3;
- However, in Stoke-on-Trent and Staffordshire, there are a larger proportion of Service Users with moderate to severe problems, and those with complex needs than the national average, therefore the allocation of Provider resources to deliver the Service should reflect this and be able to adapt to any changing needs of the population.

3.8.2 Staff skills

The IAPT implementation plan/guidance for commissioning states that at least 60% of the workforce should be employed to deliver interventions at step 3 and 40% at step 2. The IAPT minimum quality standards recommend that sufficient numbers of therapists should be employed at step 3 to meet the population needs.

A range of therapeutic skills and experience is necessary in order to meet different levels of need in IAPT clients (depression, and specific anxiety disorders), as well as Non-IAPT problems. Staff shall be required to possess a range of therapy and social care and problem solving skills supplemented with specialist areas of knowledge and practice, which shall meet the individual needs of the person.

3.8.3 Qualifications and competencies required

It is a requirement that all staff possesses the appropriate competences, qualifications and experience to perform the duties required of them. Compliance with all statutory training requirements is mandatory.

Staff delivering psychological therapies should have an appropriate level of competence and training in the relevant intervention. In addition, all senior staff shall be accredited within their level of expertise with the British Association for Behavioural and Cognitive Psychotherapies (BABCP) or working towards accreditation.

Guidance and advice on the competences / qualifications / experience expected of workers providing psychological therapy interventions is set out in guidance published by DH on IAPT Services, which is updated regularly. The service must at all times adhere to this guidance in its recruitment and training of staff.

3.8.4 Staff roles not defined under IAPT

In addition to the specific roles defined within the IAPT Programme (i.e. High Intensity Therapists and Psychological Wellbeing Practitioners) the Provider may employ staff who can address the needs of people with "Non-IAPT" mental health problems, and employment difficulties, such as:

- Community Mental Health Nurses;

- Clinical Psychologists;
- Occupational Therapists;
- Employment Advisors.

These staff must receive ongoing training and support to enable them to fulfil these roles.

3.8.5 Supervision

There must be adequate arrangements to provide appropriate levels of supervision and support to staff involved in delivering interventions at all levels. This shall cover issues related to case management and care co-ordination as well as other relevant issues. These arrangements shall be consistent with identified good practice.

3.8.6 Clinical Supervision

Staff delivering psychological therapies must have regular clinical supervision from a clinician who is fully trained in that intervention and the Provider shall be expected to set out what those arrangements are.

3.9 Location(s) of service delivery

The Service shall use a "Hub and spoke" model of delivery, with community hubs serving as a base for staff, who delivers the majority of treatment out in primary care locations across Stoke-on-Trent and Staffordshire in a range of non-stigmatising buildings, including GP practices, health centres and other primary care facilities, together with any other community facilities where these are appropriate. Treatment should not be delivered in buildings from which other secondary care mental health services are/have been delivered due to the stigma of attending these locations for people with common mental health problems.

The locations of the Service shall be decided between Commissioner and Provider but is expected that Service locations shall be equally distributed across Stoke-on-Trent and Staffordshire CCGs area.

It is imperative that Service provision is integrated with local service providers and GP practices to provide a service that meets the needs of each local area. It is recognised that there are different challenges and issues within different areas of Stoke-on-Trent and Staffordshire and it is expected that the service will be tailored to meet these where necessary.

Each general practice shall have direct access to the Service with a worker forming an integral part of the integrated primary care team through allocated time with each practice.

There shall be a local 'clinical hub' capacity that can accommodate functions such as, but not limited to:

- Access to the Service via telephone and by e-mail;
- Office space for administration, supervision and other non-clinical activity;
- Appropriate group interventions;
- Alternative venue for Service Users who prefer to be seen away from GP premises.

3.10 Days/hours of operation

The core hours for the Service shall be Monday to Friday 8am to 8pm and Saturday mornings 9.30am till 12:30pm. Additional hours shall be provided by the service should resource be available.

Service Users and referrers must be able to contact the Service by telephone, e-mail or in person during those hours.

In order to reflect the fact that Service Users may be in full time employment or have other reasons for not being able to access services within the Service's core hours, the Service shall work flexibly in response to Service User need and shall make early morning, evening and weekend appointments available to Service Users when they consider it necessary for face to face contact. Telephone-based and digital therapy and support must also be available outside the Service's core opening hours on the same basis.

The Service is not intended to be a crisis response service, therefore 24-hour cover, 7 days per week, is not required. The Service should, however, provide information to Service Users using the Service and their carer(s) where appropriate (including contact details and telephone numbers) on what to do and how to access support in the event of a crisis.

3.11 Referral pathways

The Service shall accept referral of anyone who:

- has been assessed (using one or more standard measures of mental ill health) and these measures indicate they have needs arising from common mental health problems that would benefit from the provision of psychological therapy and can be safely managed by the service or;
- in the absence of the assessment referred to in (a) above, is considered by the person or organisation making the referral to have those needs.

In both circumstances, the Service shall triage the referral to determine whether the Service is appropriate for the person referred and that the level of risk is determined.

The main sources of referral for the Service shall be via self-referral or through GPs and LTC teams, but referrals shall also be accepted from a number of other sources such as, Secondary / Specialist Mental Health Services and third sector organisations.

The Service Provider shall be expected to provide referral guidance to ensure that referrals are appropriate and managed in a timely manner and in accordance with national and local maximum waiting time targets.

If the Service determines that, the referral is unsuitable for the Service; before an assessment has been carried out the Service shall refer back to the referrer, stating clear reasons and instructions why it is not suitable.

3.12 Assessment

The majority of referrals should be self-referral by telephone. On receiving a self-referral telephone call, the Service shall:

- Ensure the call is answered by a trained clinician on duty, who can briefly assess the problem with the person, and arrange an initial appointment with them to fully assess their needs and discuss appropriate treatment options. This initial appointment shall always be on a face-to-face basis (unless the Service Users requests not to be seen face to face). A choice of times/locations should be offered – including the facility for home visits where appropriate - and appointments should take place within 2 weeks of the referral;
- If the referral is from a professional and not self-referral, the service shall contact the client to discuss their problem and arrange the initial appointment within three working days of the receipt of referral;
- Carry out a comprehensive person-centred assessment. This assessment should clearly identify the range and impact of the person's mental health needs, and should also include employment, social and physical health issues. The assessment shall confirm whether the Service User has a common mental health problem and whether the Service is appropriate to meet their needs. The assessor shall discuss the range of options / therapies available (that are appropriate for the clinical presentation) taking into consideration gender, disabilities, ethnicity and other diversity issues and other choice wherever possible;
- In terms of clinical measures, the assessment should include as a minimum the full IAPT minimum data set, a risk assessment using a recognised tool, and an IAPT measure for LTC/MUS as appropriate;
- For referrals that are appropriate for the Service, the process of referral through to initial assessment shall take no more than 14 days from the date the referral is made;
- If the outcome of the assessment indicates a requirement for referral on to specialist mental health services at Step 4, the Provider must ensure that mechanisms are in place to facilitate this;

- During the assessment, the Service shall ensure that there is a protocol in place to establish if the Service User is a Carer. If it is identified that the Service User is a Carer, then they shall be directed to appropriate services, such as The Carers Hub and with the Service Users consent, their GP will be informed.

3.13 Response times and prioritisation

The Service shall respond to routine referrals as follows:

- Initial assessment shall be within 14 days of the date of receipt of the referral;
- Following the full assessment appointment, treatment shall commence within six weeks of the completion of the assessment, in line with national standards, although ideally treatment would commence within 28 days of assessment completion. The exception to this standard would be if the Service User is not accepted for treatment by the Service;
- Where a Service User is stepped up from step 2 to step 3, they shall wait no more than 14 days for Step 3 treatment to commence and shall remain under the care of the Psychological Wellbeing Practitioner (PWP), until the case management has been transferred to a high intensity therapist;
- Where the Service User is not accepted for treatment, the referrer shall be advised of this within a maximum of 5 working days, together with the reason why they have not been accepted. Where referral needs to be made to specialist mental health services, this should take place on the same day the assessment is completed, and the referrer advised within 24 hours of this onward referral. If the referral has been made by the Service User's GP, the Service shall contact the GP by telephone where possible to advise them of this onward referral, and this shall be confirmed in writing within 24 hours;
- The Service shall make provision for urgent referrals from a GP practice to be responded to within four hours of receipt of referral and deal with those referrals with a higher level of risk assessment;
- People identified to be at high risk (e.g. suicidal intention, severe self-injurious behaviour, psychotic symptomatology) should be referred urgently to the appropriate mental health service;
- The Service Provider shall take reasonable steps to minimise the incidence of non-attendance of Service Users to all appointments and shall demonstrate how this will be achieved, including any innovative approaches.

3.14 Treatment system

Once an individual is assessed their pathway shall be based on interventions to address individual need – this would take into account the stepped care model (including recommended treatments according to NICE guidelines for anxiety and depression) but in addition services to also support functionality and social well-being.

The expectation is that Service Users shall be offered the least intensive intervention that is supported by the NICE guidelines.

All Service Users shall be offered the option of face-to-face intervention in the first instance. The Service shall provide treatments specified in NICE guidance on Stepped Care as being appropriate to Step 2 and Step 3. However, the Service responses should be tailored to meet individual needs in all cases.

3.14.1 Step 1 Services

Step 1 services shall be focused on improving the identification and awareness of common mental health problems and ensuring that there are pathways to care and shall include the interventions detailed below:

Fig. 7: Step 1 services – focus and nature of intervention

Focus of the intervention

Nature of the intervention

| | |
|--|--|
| <ul style="list-style-type: none"> • Presentation with known or suspected common mental health disorders | <ul style="list-style-type: none"> • Identification • Assessment • Psychoeducation • Active monitoring • Referral for further assessment and interventions. |
|--|--|

3.14.2 Step 2 Services

Step 2 services are generally low-intensity services and shall include the interventions detailed below. They should be available as individual and group sessions (where these are recommended in NICE guidance) and should include both brief face-to-face contact and telephone/text support.

Fig. 8: Step 2 services – focus and nature of intervention

| Psychological intervention | Disorder |
|---|--|
| <ul style="list-style-type: none"> • Cognitive behaviour therapy (computerised) | <ul style="list-style-type: none"> • Depression |
| <ul style="list-style-type: none"> • Psycho-educational / Self-help groups | <ul style="list-style-type: none"> • Generalised anxiety disorder |
| <ul style="list-style-type: none"> • Guided Self-help (individual facilitated) | <ul style="list-style-type: none"> • Depression • Generalised anxiety disorder • Panic disorder |
| <ul style="list-style-type: none"> • Self-help (individual non-facilitated) | <ul style="list-style-type: none"> • Generalised anxiety disorder • Panic disorder |

3.14.3 Step 3 Services

Step 3 services are generally high-intensity services and shall include the interventions detailed in fig. 9 below. They should be available as individual and group sessions (where these are recommended in NICE guidance) and should be conducted via face-to-face contact.

Fig. 9: Step 3 services – focus and nature of intervention

| Psychological intervention | Disorder |
|---|---|
| <ul style="list-style-type: none"> • Applied relaxation | <ul style="list-style-type: none"> • Generalised anxiety disorder |
| <ul style="list-style-type: none"> • Behavioural activation | <ul style="list-style-type: none"> • Depression |
| <ul style="list-style-type: none"> • Behavioural couples therapy | <ul style="list-style-type: none"> • Depression |
| <ul style="list-style-type: none"> • Bibliotherapy based on cognitive behavioural therapy principles | <ul style="list-style-type: none"> • Panic disorder |
| <ul style="list-style-type: none"> • Cognitive behavioural therapy (CBT) | <ul style="list-style-type: none"> • Depression • Generalised anxiety disorder • Panic disorder (with or without Agoraphobia) • Social Phobia • Specific Phobias • Health Anxiety • Body Dysmorphic Disorder |
| <ul style="list-style-type: none"> • Cognitive behavioural therapy including exposure and response prevention | <ul style="list-style-type: none"> • Obsessive-compulsive disorder |
| <ul style="list-style-type: none"> • Cognitive behavioural therapy (trauma-focused) | <ul style="list-style-type: none"> • Post-traumatic stress disorder |

| | |
|--|--|
| <ul style="list-style-type: none"> • Counselling | <ul style="list-style-type: none"> • Depression (for people who decline an antidepressant, cognitive behavioural therapy, interpersonal psychotherapy, behavioural activation or behavioural couples therapy) |
| <ul style="list-style-type: none"> • Eye movement desensitising and reprocessing | <ul style="list-style-type: none"> • Post-traumatic stress disorder |
| <ul style="list-style-type: none"> • Interpersonal psychotherapy | <ul style="list-style-type: none"> • Depression |

The treatment systems can also include (but not exclusively) any of the interventions described below in accordance with NICE Guidance:

- Cognitive Behavioural Therapy (Anxiety Disorders and Depression);
- Interpersonal Therapy (Depression);
- Behavioural Couples Therapy (Depression);
- Person Centred Counselling (Mild Depression);
- Brief Psychodynamic Therapy (Mild Depression);
- Behavioural activation;
- Eye movement desensitisation and reprocessing (EMDR).

Whichever treatment system is provided to the Service User, the use of validated evidence-based assessment, monitoring and outcome tools should be used. Where there are potential alternatives treatments, Service Users should always be offered choices of their preferred treatment.

Once agreement has been reached on the therapy to be provided, a plan shall be agreed with the Service Users to include:

- Required outcomes;
- Nature and duration of interventions or support to be provided;
- Named team member(s) who shall be the case manager and / or be providing the services, together with their contact details;
- Wherever possible, a schedule of appointments or at least an indication of their frequency.

3.15 Case management

Each Service User, for whom a treatment plan is agreed, shall have a designated case manager.

Case management responsibilities are to ensure that:

- The agreed treatment plan is delivered;
- Service Users are contacted / followed up if they do not attend agreed appointments;
- Progress against agreed outcomes is monitored, reviewed and reported, including:
 - Where the case manager has the necessary expertise;
 - Identifying needs to step up or down the level of intervention.
- Information collection requirements are met.

The designated case manager may also be the person providing the interventions set out in the treatment plan.

Case management responsibilities should be allocated appropriate to the level of expertise of the staff member involved.

3.16 Medication

Responsibility for prescribing medication shall normally remain with the Service User's GP. However, the Service's staff shall need to have expertise in how medication can be used in conjunction with psychological therapies, shall be able to support Service Users in making decisions about their use of medication in an informed way and shall liaise with GPs over any potential issues and possible changes to medication.

3.17 Discharge

Service Users shall be discharged from the Service when their treatment is complete. This means one or more of the following has occurred:

- They have received one contact from the Service and this has been effective in addressing their needs. This could include signposting to another appropriate service following initial assessment;
- They have received two or more contacts with the Service, and have achieved “recovery” as defined within the IAPT programme, using the relevant clinical measures (e.g. PHQ9, GAD7, Diabetes distress scale, COPD assessment test, Brief Pain Inventory etc);
- Responsibility for their care has been transferred to another organisation and they have been referred to another organisation and this referral has been accepted. This includes transfers to specialist mental health services;
- They have failed to attend face-to-face appointments on at least three consecutive occasions, or they have failed to respond on at least three consecutive occasions to appointments for telephone contact as part of treatment and have not responded to any further contact attempts by the Service either by telephone or in writing;
- They have advised the Service that they no longer wish to continue with treatment;
- They have left the area;
- They have died;
- Where a Service Users has either failed to engage with or has been discharged from the Service, they shall have the option to enter back into the Service, without the need for a re-referral from their GP.

3.18 Communication

The Service shall contact the referrer at three specific points during treatment:

- At assessment, to advise them of the outcome, the identified problem, and what treatment has been offered/accepted;
- At the start of treatment to inform them that this has commenced;
- On discharge from treatment, to advise them that treatment is completed, or the Service User has failed to remain in contact with the Service.

In all cases, the information provided shall include reference to the relevant measures used to assess the Service Users’ mental health and wellbeing.

In all circumstances other than where the GP has made the referral, the Service User’s GP shall also, with the Service Users’ consent, be advised of the referral and its outcome, of the treatment being undertaken and its progress, together with the outcome of the treatment and the Service User’s discharge from the Service.

If the waiting times for treatment exceed the expected standard (six weeks) then the Service shall inform the Service Users and the Service Users GP.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The Service shall ensure that it adheres to relevant national standards of best practice in mental health provisions, to the most recent NICE guidance and other reliable sources of evidence, for example:

- NICE clinical guideline 123: [Common mental health disorders: identification and pathways to care](#)
- NICE clinical guideline 113: [Generalised anxiety disorder and panic disorder \(with or without agoraphobia\) in adults](#)

- NICE clinical guideline 91: [The treatment and management of depression in adults with chronic physical health problems \(partial update of CG23\)](#)
- NICE clinical guideline 90: [The treatment and management of depression in adults \(update\)](#)
- NICE clinical guideline 31: [Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder](#)
- NICE clinical guideline 26: [Post-traumatic stress disorder \(PTSD\): The management of PTSD in adults and children in primary and secondary care](#)
- NICE clinical guideline 159: [Social anxiety disorder: recognition, assessment and treatment of social anxiety disorder](#)
- NICE quality standard: Depression in adults
- NICE pathway: [Depression in adults](#)
- NHS England Accessible Information Standard

The Provider shall comply with IAPT requirements, including the Information Standards:

- The IAPT data set standard specification ISB 1520;
- The IAPT Data Handbook (<https://webarchive.nationalarchives.gov.uk/20160302155413/http://www.iapt.nhs.uk/silo/files/data-set-v15.pdf>).

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Not used

4.3 Applicable local standards

Not used

4.4 Reporting Standards

The Provider shall be required to collect, collate, manage and provide information to the commissioner and for national mandatory collection purposes as set out in the IAPT data framework, and in line with the core national information standards.

The Provider shall be expected to provide audit data on a monthly basis to the commissioner to understand the level of activity and whether the average length of Service User pathway is as expected.

The Clinical Leads for the service will provide clear written guidance, criteria and protocols for all clinical staff to follow, regarding the recording of clinical appointments and outcome measures (e.g. the definition of a “Treatment” appointment vs “Assessment” or “Review”). This will ensure consistency in reporting behaviour across all teams and sub-contracted providers.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C for full details)

The following indicators are key targets of the IAPT programme:

- Increase the proportion of people referred access a course of treatment from 15% to 25% by 2020/21;
- 75% of referrals that have a course of treatment should have their first treatment session within 6 weeks of referral;
- 95% of referrals that have a course of treatment should have their first treatment session within 18 weeks of referral;
- 90% of patients that should wait no longer than 90 days between 1st and 2nd treatment;

- 50% of people treated in IAPT services should move towards recovery;
- A minimum of 90% data completeness for pre/post treatment scores for both depression and anxiety/MUS measures;
- DNA rates: minimise the number of patients who do not attend their appointment

For further detail on how these indicators are defined and measured, please refer to section 6.4 of the [IAPT manual](#).

5.2 Applicable CQUIN goals (See Schedule 4D for full details)

6. Location of Provider Premises

6.1 The Provider's Premises are located at:

The Psychological Service will be delivered from a range of community venues. The face to face primary psychological care for mental health must be delivered in an environment which is conducive to the needs of the individual, offering anonymity if required.

- Delivered close to patient's homes wherever possible (and in patient's own homes where they are housebound or have prohibitive mobility issues). Definition of housebound to be attached somewhere and individual agreed as housebound with GP;
- Provided in a range of community settings (GP practices, libraries, resource centres and employment settings), ensuring these are accessible for patients e.g. hearing loop available for patients with hearing loss;
- Includes appropriate space to accommodate core functions (e.g. PWP telephone advice; small group work; video feedback role play; consulting space for patients who wish/need to be seen away from GP practice);
- Integrated within local healthcare systems;
- In a location well-served by public transport;
- Services would need to be provided in easily accessible locations which reflect local health needs;
- Office space for administration.

7. Individual Service User Placement